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“Physician Aid in Dying: Neither Compassionate nor a Choice”

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Ms. Z was a 78 year-old grandmother who was articulate, thoughtful and exhausted. Her suffering had worn on her body and her many illnesses had succeeded in defeating her spirit. The arthritis felt like sandpaper between her joints and her heart disease limited her ability to function without the aid of those who cared for her. Prior to my assuming her care in the hospital, she had asserted that she would like to die...and die soon. Due to her heart disease, she only had a few months to live. Psychiatry had ensured she was capable to change her goals of care away from therapies; they further assured that she was not depressed. Her mind was sharp, but her body was weak. I knew she was serious when the nurse called me because she wrapped a telephone cord around her neck in an act of desperation, saying she wanted to die. I sat with her and her family for multiple hours discussing her desires. She had had enough.

The debate for physician-assisted suicide has been reinvigorated this year in the Connecticut State Legislature due to the efforts of the pro-euthanasia, nonprofit *Compassion and Choices*. *Compassion and Choices* is the force attempting, via emotional campaigning and a large injection of external funds, to influence Connecticut’s legislature and public opinion.

As a physician, I am committed to delivering the most compassionate care possible. This includes partnering with patients in an effort to cure illness, do no harm while delivering care, and lessen suffering. The word *compassion* literally means, “to suffer with.” The doctor-patient and nurse-patient relationship can be an extremely intimate partnership where the patient shares her suffering with the caregiver. It would be extremely naïve to quip that a physician or nurse truly feels the suffering or pains that the patient endures, but in order to deliver care, a physician must enter in to the condition of being human with the patient. When a physician, nurse, or loved-one partners with a patient in their care, they are asking permission to celebrate in the patient’s joy, to hurt when the patient hurts, or to cry when the patient cries.

When *compassion* is taken literally to mean, “to suffer with,” physician-assisted suicide is the farthest thing from compassionate care. A physician is to stand alongside the patient, hold her hand, and relieve suffering when possible. Life-ending treatment affirms that the physician is ready to dissolve this partnership.

Ill patients make choices daily about their desired care. A person’s ability to make an informed decision about her own care without any coercion is termed *autonomy*. An autonomous decision is seriously threatened when serious pain or suffering is present. It has been stated, “sickness is the greatest thief of autonomy.” A hospital bed is an incredibly vulnerable position where a patient’s hope is to be healed or palliated, but various competing external forces and internal conflicts also influence these suffering individuals. The *Compassion and Choices* campaign laud when an individual decides on her “own terms” when and how to die. This assertion fails to consider the frailty of the mind and brokenness of spirit in individuals who would be expected to make this decision. An individual’s ability to make an informed decision about her care is at risk when experiencing any type of pain or illness. Numerous medical studies have revealed that an overwhelming minority of patients have voiced their advanced directives (i.e., the desire for CPR and/or life support, if necessary) to their loved-ones at any point prior to becoming ill. If

advanced directives are infrequently voiced to family members, why offer life-ending medications to an individual when she is in the most vulnerable of positions? The proponent of physician-assisted suicide may assert that physician-assisted suicide is for a minority of informed patients, but if legalized, it is on the buffet of treatment options for all patients who are deemed competent...even those who have not been informed.

The marching orders of the *Compassion and Choices* campaign are: “My life. My death. My choice.” The frailty of judgment and reasonable (and probable) societal next steps are rarely considered when campaigns, fraught with emotion, are seemingly fought on behalf of an individual’s preference. Governing bodies often rush to legislative action while disregarding history or probable outcomes of such action when taken to its logical conclusions (i.e. forced and/or coerced euthanasia for persons undesirable to a society have been utilized in many nations). It is exceedingly arrogant of *Compassion and Choices* to disregard that their desired legislation has not been carried out in the past. The checkered history of physician-assisted suicide has not adequately been considered during Connecticut’s public discourse on this issue. The history of euthanasia and patterns of euthanasia in use in contemporary Europe (including pediatric euthanasia) is a necessary consideration for Nutmeggers. Furthermore, this law opens the door for imposition of values of those in power (physicians, family members, etc) on those most susceptible (the patient).

Ms. Z vacillated between “wanting to die” and continuing to receive treatment, but she was extremely clear that she would end her life if given the opportunity. As the days passed in her treatment, she expressed that she was frightened she physically would not return to being the person she had been. She was terrified she would be unable to live in her own home. Her tears expressed that she did not want to be a burden to her family for care. She felt the financial strain that her family would experience. Her fears culminated in an expression of wanting to die because she had always been self-reliant and was unable to utter these palpable trepidations. Her judgment, as she later confirmed, was wholly clouded by her fears. Her apprehensions are not that dissimilar to fears I encounter daily among my elderly patients. Those from the Greatest Generation are an extremely strong, proud people who are slow to accept assistance from even their closest loved ones.

As a physician, I am extremely uneasy to support legislative action where a patient’s decision may not truly be her decision. Offering medications to facilitate death is not consistent with the social contract to deliver compassionate care that the medical community has with those who are most vulnerable in our state. The question of physician-aid in death is not just a question for the medical community it is a question for all who live (and die) in Connecticut. This is a question of what type of people we would like to be. Do we want to be a compassionate people who choose to stand in solidarity, palliate suffering, and suffer with our loved ones in their hardest and most vulnerable time?